A.I.D.K.A Australia
Personal injury claim form

QBE Insurance (Australia) Limited ABN 78 003 191 035 AFSL 239 545

Please Remember

Any incomplete or non-completed forms may delay processing of your claim. Please ensure that you have completed/attached the following:

- ☐ All sections in the claim form
- ☐ Signed and dated the declaration form
- ☐ Any written medical reports by medical practitioner from within the 12 months of the disability
- ☐ Proof of identification (Certified copy of drivers license or passport)
- ☐ Tax file number declaration (TFN)

PLEASE NOTE

When the claim form has been completed in full, signed and dated please send it, with attachments, to:-

Australian Independent Dirt Kart Association Inc. (A.I.D.K.A. Inc.)

AIDKA Secretary

PO BOX 1108

LOXTON SA 5333

secretary@aidka.com.au

If you have any enquires, or if you need assistance with understanding or completing this form, you may contact A.I.D.K.A Australia. Please ensure that you keep copies of all documentation sent to A.I.D.K.A Australia. All correctly completed documentation received by A.I.D.K.A Australia will be forwarded to the insurers who will make direct contact with you.

IMPORTANT NOTE

DO NOT forward claim forms directly to the Insurer. Forward all claims with a copy of your licence to the A.I.D.K.A Australia office.

DO NOT forward unpaid medical or ambulance accounts with Claim Forms. All accounts should be paid and receipts forwarded with the Claim Form for reimbursement.

DO NOT forward copies of accounts or receipts. All accounts and receipts should be originals.

DO NOT forward Medicare receipts.

Payment details

Please choose your preferred payment method below.

Australian bank account

Name of Bank/Credit Union		Account name	
BSB		Account number	

Australian dollar cheque (please provide address on separate sheet if required)

Yes ☐ No ☐

Claimant certification

Name of club or association of which you are a member:	
Club at which accident occurred:	
Vehicle category competing in at time of accident:	

Your details

Name			
Address			
Email		Date of birth	

Do you consent to receive important information about your claim via email? Yes ☐ No ☐

Telephone	Home		Work		Mobile	
Occupation					
Usual duties					

In what capacity were you participating in the meet?

☐ Driver	☐ Official	☐ Mechanic	☐ Other (please specify)

Declaration of earnings

IMPORTANT INFORMATION

1. If you are self-employed, Weekly Earnings means your weekly earnings derived from personal exertion after allowing for the cost and expenses in incurring that income. Please complete Section 1.

2. If you are not self-employed, Weekly Earnings means your weekly remuneration earned from personal exertion by way of salary, fees, wages, commissions and any other items already agreed by us. Please complete Section 2.

3. You may be required to supply proof of your income by submitting copies of your personal and/or business income tax returns for the full financial year immediately preceding the injury or illness for which you are now claiming.

Section 1: Self employed persons (to be completed by your accountant)

Business/Trading Name	
Address	
Current weekly earnings (see important information 1 above)	
Accountants Name	
Accountants Signature	

Section 2: Employed persons (to be completed by employer)

Business/Trading Name	
Address	
Current weekly earnings (see important information 2 above)	

Details of injury

Give full description of injury from which you are suffering. (attach extra page if necessary)

Type of Injury			
How did injury occur			
Where did the injury occur			
Date of Injury		Time	
Date of disablement			
Name of person/s who witnessed the accident		Phone	

Was the activity in which you were engaged, at the time you injured yourself, an activity which was sanctioned and scheduled by the insured organisation?

Yes ☐ No ☐

Have you had any other injuries to similar parts of the body? (If yes please attach extra page with details)

Yes ☐ No ☐

Are you aware of any previous medical history, health issues or injuries that may affect your recovery from the injury or illness? (If yes please attach page with details)

Yes ☐ No ☐

Are you claiming from any other insurance or compensation claim in respect of disability?

Yes ☐ No ☐

If yes please provide details below.

Type of Insurance	
Company	

Privacy

Our Privacy Policy describes how we collect, disclose, store and use personal information as well as how to access it, correct it or make a complaint. When we say personal information we may also mean sensitive information such as health information, criminal history or professional memberships that's relevant to us issuing, administering or managing products or providing services and the terms on which we will do these things. We use personal information to issue, administer and manage products and provide services. You can view our Privacy Policy at www.qbe.com.au/privacy, or to obtain a copy by phoning us on 133 723 or requesting it from our authorised representatives or service providers.

We may share your information with other QBE Group companies, our authorised representatives and service providers, each of which may be based outside of Australia.

By giving us personal information you consent to us collecting, disclosing, storing and using it in accordance with our Privacy Policy. If you give us someone else's personal information you confirm you've obtained their consent to do so.

If you don't provide all of the personal information we've requested we may be unable to issue, administer or manage products or provide services.

Payment declaration and authorisation

The information and answers given above are true, correct and complete in every detail.

1. I understand the claim may be refused if information is not true or is withheld.
2. I authorise QBE to give to and obtain from other insurers, insurance reference bureaus any information relating to my insurance history as well as insurance claims information obtained during the course of this contract.

Medical Authority: I authorise any hospital, physician or other person who attended me, to give QBE or its representative any or all information with respect to any illness or injury, medical history, consultation, prescription, or treatment, and copies of all hospital or medical records. I also agree that copies of all employer records including verification of earnings can be provided.

A photocopy of this authorisation will be considered as effective and valid as the original.

Signature		Date	

Attending physician's statement

Important – your medical practitioner must complete the attending physician's statement. Your claim cannot be processed until we receive your completed claim together with the attending physician's statement. Any charge for this statement must be borne by the patient. Please complete all sections.

Patient's Name				
Address				
	State		Postcode	

HISTORY:

When did the patient first receive medical treatment?	
Was there a previous history of this or a similar condition?	Yes ☐ No ☐

If yes, please state condition and advise when previous treatment given.

How long have you known the patient?	
Are you the regular general practitioner? If no please advise who is?	Yes ☐ No ☐

When did the patient suffer the injury?	Date		Time	

What were the circumstances surrounding the injury?

Degree of Disability

When was the patient obliged to cease work?	Date		Time	

If the patient is still disabled, when will the patient be able to resume:

One or more of the material tasks of occupation?		All tasks of their occupation?	

If the patient has recovered, when was the patient able to resume:

One or more of the material tasks of occupation?		All tasks of their occupation?	

Treatment of present condition

1. When were you consulted?

a) Initially?		b) Most recently?	

2. How often has the patient consulted you?				
3. Was the patient confined to hospital?	Yes ☐ No ☐			
If yes please advise Hospital name				
Address				
Period of confinement	From		To	
4. Was confinement in a convalescent home necessary after hospitalisation?	Yes ☐ No ☐			
If yes please give details				
5. What are the current subjective symptoms?				

6. Please give results of any objective finding

a) X-rays	
b) Other test - Please advise test done and findings	
7. What surgical procedures have been performed?	
8. What surgical procedures have been contemplated?	
9. What other treatment has the patient undergone?	
10. What other treatment is required? (Please provide treatment/management plan)	

Are there any underlying conditions affecting recovery from the current condition? Yes ☐ No ☐
If yes please advise nature of underlying conditions and how they affect disability and recovery.

Do you believe occupational rehabilitation would benefit this patient? Yes ☐ No ☐

If you have terminated treatment, please advise date	

What is your current prognosis?

Are there any further remarks which may assist in assessing this condition?

Is there any permanent disability present? Yes ☐ No ☐
If yes, please explain giving estimated percentage of loss of function.

Name (please print name)	Address	Telephone
Signature	**Qualifications**	**Date**

Club certification

This part of the claim form needs to be completed by a A.I.D.K.A Australia Administration Officer

Name of injured person	
Event participating in	
Name of the club	
Address of the club	

1) On what date did the licence holder of the insured organisation sustain the injury?	
2) Was the activity in which the licence holder of the organisation was participating; at the time of injury an officially authorised and sanctioned activity of the insured organisation?	Yes ☐ No ☐
3) What is the injured person's licence holder number?	
4) Was the injured person an annual licence holder of the insured organisation at the date of injury? (if not proceed to question 5)	Yes ☐ No ☐
5) Did the injured person possess a day licence of the insured organisation at the date of injury? (if not proceed to question 6)	Yes ☐ No ☐
6) Did the injured person possess a pit pass of the insured organisation at the date of injury?	Yes ☐ No ☐

Club declaration

I am an officer of A.I.D.K.A Australia. I declare that the information provided in this certification is true, correct and completed to the best of my ability.

Name		Title of office bearer	
Signature		Date	